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## CONTENTS.



# CLINICAL LECTURES.

## ON ACUTE INFECTIOUS DISEASE.

*A Clinical Lecture delivered at the Good Samaritan Hospital, Cincinnati.*

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GENTLEMEN: When we last met we had before us a typical case of typhoid fever in the height of the disease. We saw displayed, one by one, the signs which characterize the affection, and which, in group, put upon any case of it the stamp of individuality. We have next to discuss the most interesting question connected with its history, viz., its cause. No knowledge satisfies short of the cause, for, as Bacon has said, "*Vere scire est per causas scire.*"

When we come to study the cause of typhoid fever, we confront, at once, the cause of all acute infectious diseases, of which this malady, pre-eminently, is one. While each one of these diseases has individual points of difference, they have all many more points in common, both as regards the symptoms they induce and the lesions they present. If we look, for instance, at yellow fever, the prevalence of which at the present time intensifies our interest in this subject,—a disease which would seem, on account of its localization, to stand apart from the rest,—

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we discover nothing especially secret and peculiar, nothing which might confer upon those most familiar with it special skill in its management or relief; for the initial chill (when present), the intense frontal and lumbar pain, the fever and gastric disturbance, belong to all the exanthematous diseases. Albuminuria occurs in every high fever which markedly lowers capillary tone. Vomiting of disorganized blood (the ominous black vomit) is a characteristic also of typhus, and bad cases of typhoid fevers, hemorrhagic smallpox, and malarial remittents. The distinct and deceptive remission of all the symptoms, the pathognomonic bronzed or mahogany colouration of the skin and mucous membranes, alike distinguishes icterus gravis, some varieties of septicæmia, and chronic malarial poisoning.

Moreover, yellow fever has no discoverable pathological lesion absolutely peculiar to itself. The hematogenous icterus and ecchymosis of the skin, the hemorrhagic erosions of the stomach, with its bloody contents, the anæmic, mostly acutely fatty liver, the hyperæmic and blocked-up kidneys, with, in *foudroyante* and protracted cases, the nearly or quite empty bladder, the granular and fatty degeneration of the muscles, the general catarrh of the mucosæ everywhere—what are all these conditions but signs common to every acute toxicæmia?

We cannot, therefore, study intelligently the etiology of any one of these diseases without a preliminary survey of the entire field.

I do not need to say to you that no subject in medicine is more worthy of our time. The occurrence of an epidemic of acute infectious disease strikes terror as no other calamity or casualty of nature, for the simple reason that no one is so universal or wide-spread in its reach. Those of us who have been eye-witnesses of the devastations of cholera and yellow fever need no reference to the epidemics of the middle ages for full appreciation of the horrors of a plague. Even as we speak there threatens to be left of one of the most populous cities of our Valley, now nearly deserted of its inhabitants, what was left of its namesake of old, merely "a tomb and a shadowy name."

A vast number of facts have been accumulated about these mysterious infectious diseases, many errors have been corrected, many suspicions dispelled or confirmed, until we can almost say that we possess as much definite information regarding the cause of acute infectious disease as regarding the ultimate essence of any other natural phenomena.

This class of diseases, a specimen of one of which has so lately occupied our attention, is especially characterized by more or less rapid dissemination, by intensity or virulence of manifestation, and by comparative shortness of duration. With these characteristics this class of diseases is appropriately grouped under the title of the Acute Infectious Diseases.

The course and conduct of these diseases in the body resemble, to some extent, the action of poisons; hence they are often called blood-poisoning, or septic diseases.

The poison, whatever its nature, once introduced, in however small quantity, into the blood, so swiftly induces manifestations of disease in the whole body, as to resemble the action of a yeast or ferment, a little of which "leaveneth the whole lump," and hence these diseases are also called Zymotic Diseases.

Finally, because these diseases, under the unfavourable hygienic conditions which still surround us, are able to spread over whole sections of country, over whole countries, indeed, unless checked by natural causes, over the whole globe, they constitute what are known everywhere as the Epidemic or Pandemic Diseases.

Types of these diseases are Asiatic cholera, smallpox, chicken-pox, measles, scarlet fever, typhus and typhoid fevers, yellow fever, and diphtheria. In the very forefront of the acute infectious diseases stands, or stood—for our improved sanitary conditions, faulty as they still are, have prevented its spread in modern times—that most terrible of all scourges to man, the plague. At the extreme opposite end of the list, we may read mumps, whooping-cough, and influenza (a marked

sample of which, the "epizootic" of 1873, confined nearly every horse of this country to his stall for several days); and along the column at different places, erysipelas, child-bed fever, and dysentery when epidemic, as in ships, hospitals, and camps; pyæmia and septicæmia; with vaccinia, hydrophobia, malignant pustule, etc., as poisons communicated from lower animals to man, and the cattle plague as a typical example of this class of affections in the lower animals themselves.

The characteristic feature of all these diseases is infection. It matters not that they are not all propagated by immediate, direct, or personal contact. In some diseases, the infectious element is fixed close to the body, as in cow-pox and syphilis. These are diseases never propagated by the air, though great stress was put upon the telluric origin of syphilis by a priest who wrote one of the earliest accounts of the disease, as it manifested itself in his own person. In other diseases, smallpox, measles, scarlet fever, the poison is eminently volatile, and is thus disseminated by the air. In still other cases, as in typhoid fever, dysentery and cholera, it is the dejections which chiefly convey the contagium to finally infect the soil and through the soil or sewage canals, by filtration to even great distance, the drinking waters of our wells and cisterns and running streams. To breathe infected air or drink infected water, quite distant from the focus of infection, suffices to engender cholera, dysentery, or typhoid fever, while the contagion of syphilis, and probably diphtheria, must be lodged upon the mucous membranes; and vaccinia, hydrophobia, malignant pustule, the virus from venomous animals, to produce infection, must be inoculated into the very blood itself.

The mode of infection has thus been pretty accurately determined for each of the acute infectious diseases.

Another fact of equal value is the recognition of the specificity of these diseases. Each one of these diseases is known to reproduce itself alone. Measles begets measles, smallpox begets smallpox, cholera begets cholera. Figs would be born of thorns or grapes of thistles as soon as cholera of smallpox, or diphtheria of typhoid fever. The introduction into the blood of the specific cause begets the specific disease.

From this law has been deduced still another fact inestimable in its value: and that is that the spontaneous generation of any one of these diseases is impossible and unknown. Nowhere now is there any question of autochthonous genesis of infectious disease. Everywhere is recognized a house where the disease is indigenous, and a route along which it is spread. The mouths of the Ganges and Brahmaputra are the centres of cholera, lower Egypt of the plague, the Antilles of yellow fever, Ireland of typhus. So far as these diseases are concerned, whose course can be most distinctly traced—cholera and yellow fever, for instance—the line of infection, when accurately pursued, is always found to correspond with the line of transportation by water or rail. The increased velocity of travel in our day, with the correspondingly increased swiftness of the transportation of disease, forms the embarrassing element in tracing the course of disease to its original seat. A week and two days may now suffice to introduce from Europe to our whole country a sweeping epidemic of cholera, and, under favouring conditions, but a few days are required to carry yellow fever from New Orleans to New York. Thus the advanced knowledge of sanitary science in our day, to which we may chiefly ascribe our comparative exemption from the devastating epidemics of ancient times, is counteracted to some extent by the increased facilities for transportation of disease to new centres, the absence of which alone saved the human race in the middle ages from almost utter extinction.

Smallpox first showed itself in Germany in 1493, an importation from the Netherlands, but it was not until 1527 that it was transported to our country, making its first appearance in Mexico, slaughtering myriads, and then gradually extending over the whole of North America. Scarlet fever, which was first seen in our country in 1735, reached Iceland in 1827, South America in 1829, Greenland in

1847, and Australia in 1848. Measles has not yet been carried to Australia. Cerebro-spinal meningitis, in every respect the most irregular of all epidemic diseases, first fell upon our country in 1806. The ocean was for all time an impassable barrier to cholera, the most wide spread and fatal of all the acute infectious diseases, until it was directly conveyed across in the memorable year of 1832.

The last case of measles in the Faroe islands occurred in 1781. The disease then died out and was almost forgotten, when, in 1846, an individual sick with it came ashore. The inhabitants at that time numbered 7782. Of these, over 6000 fell sick with the measles, and the 1500 that escaped owed their safety to rigid quarantine. On the affected islands, the attack was nearly universal, only the very aged, who had suffered with the disease during and previous to 1781 were spared.

No point in prophylaxis could be of greater value than the recognition of the exclusively parental birth of acute infectious disease.

The close observation of a long series of years has already put us in possession, moreover, of most of the data in the natural history of each of these diseases Thus we have learned first that manifest attack does not follow immediately upon exposure to the disease. There lapses first a period during which the disease lies latent in the body, hatching as it were, the so-called period of incubation. In some cases the length of this period may be determined to a day, by the experiment of inoculation. Thus, the incubation period of vaccinia is 3 days, of smallpox after inoculation 2 days, without inoculation 12–18 days, of scarlet fever 4–7 days, of typhus 7–14 days, of typhoid fever 12–16 days, of measles 10 days, of intermittent fever 1–14 days, of syphilis 2–4 weeks, of the plague 2–7 days, of cholera 2–3 days, of yellow fever 2–9 days, of hydrophobia 8–60 days.

Then supervene the various stages characteristic of each disease, each stage, of more or less definite duration, marking off a definite phase in the course of each disease. We know, again, what are the infecting structures, what is the period of greatest infection, and what is the duration of infection, for each disease.

Lastly, the proof accumulates day by day that all or nearly all the acute infectious diseases are caused by microscopic, or ultra-microscopic parasites, endowed with marvellous powers of reproduction. "From a single germ of the saccharomyces cerevisiæ, the well-known alcoholic ferment, 100 tons of yeast, containing possibly 50 milliards cells, have been generated in a single day in some of our largest breweries." A single drop of fluid containing the bacteria of *milz brand* introduced into the blood of the largest ox, multiplies its poison to such almost incredible degree as to kill the animal in 24–36 hours. In this disease, in relapsing fever, charbon, and septicæmia, the kind and conduct of infecting parasites have been as clearly demonstrated and described as in scabies and trichinosis.

But these parasites or germs do not always multiply in the blood or in the body; hence, not all acute infectious diseases are contagious. Smallpox gives off its contagion from its eruption in greatest virulence just before the vesicle becomes a pustule, in the exhalations from the skin, and in the blood, from which even the placenta does not filter it off. In measles, the disease may be inoculated with the blood, the tears, and the sputum. Scarlet fever infection is in the exhalations from the skin and lungs, and that of typhus irradiates in every direction from every surface and secretion. These are eminently the contagious diseases. In the case of others, yellow fever, malarial fevers, the poison is in no sense entogenous, the germs productive of the disease do not multiply in the blood, nor migrate from it to others about the infected individual. Local colonization, universal dissemination marks the history of the purely contagious diseases; colonization and chemical change characterize those which remain simply infectious.

Gentlemen, we have no time to speak now of the easy solution of all the problems offered by the germ genesis of the acute infectious disease. I shall simply call your attention to an explanation it permits of the so-called sporadic cases of

disease where the closest search has failed to reveal a primal cause. I venture it only as a possible explanation, because fortunately most of the poisons of disease are known to hug the ground, to be dissolved in the subsoil water, or at most to creep (when not carried) at almost snail's pace along the surface of the earth. But an ascending column of air, laden with the poison, might be wafted off to very distant seats. That this offered explanation is no mere conception of fancy, is shown by the abundant records of the fall of dust, mostly infusoria, upon vessels far out (1000–1600 miles) at sea. Such clouds of dust have even compelled vessels to put ashore. Mr. Darwin, in his Voyage, says: "In some dust which was collected on a vessel 300 miles from the land, I was much surprised to find particles of stone above the thousandth of an inch square, mixed with finer matter," and adds, "After this fact one need not be surprised at the diffusion of the far lighter and smaller sporules of cryptogamic plants."

Gentlemen, need we be surprised at the occasional occurrence of a sporadic case, at the distant dissemination of acute infectious disease dependent upon germs, when a single bacterium weighs only 0.00000000157, not the millionth part of a milligramme?

The recognition of the fact that these diseases are never spontaneous in development, but that their germs are always somewhere in lurk, would protect us in great measure from invasion, or if invaded, would restrict their dissemination to the narrowest possible limits. Pure water, pure air, and absolute cleanliness, disinfection, rigid and relentless quarantine, and, in proper cases, isolation of the sick, then suggest themselves at once.

In accepting the germ theory as the cause of infectious disease, we have at least a tangible material foe against which to shoot a lance. We are not simply fighting air, comets or eclipses, or supernatural dragons. We are relieved, at once, in therapy from the dreadful nightmare of empiricism.

Our government has at last been awakened to the necessity of a National Board of Health, which gives fair promise already of much good. What is most needed at the present time is the appointment of scientific epidemiologists by the different States, *in loco morbi*, at salaries sufficient to relieve them from the time-consuming necessities of practice. A small fraction of the donations so benevolently contributed during the calamities entailed by epidemics, would probably secure such disclosures concerning the cause, prevention, and cure of infectious disease as would effectually efface them. Whether these disclosures would be the discovery of antidotes like quinia for malaria, or mercury for syphilis; or preventives, like vaccinia, for the smallpox; or conditions which mitigate the dangers, like refrigeration, charbon; it is impossible as yet to say. But it is perfectly safe, with our present knowledge, to predict the speedy extinction of many infectious diseases, the existence of which, at the present time, is a disgrace to medical science and a satire upon civilization.

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### HOSPITAL NOTES AND GLEANINGS.

*Popliteal Aneurism; Preparatory Treatment; Compression; Cure; Remarks* — This patient, a man, fifty-seven years of age, was admitted into the London Hospital, under the care of Mr. JONATHAN HUTCHINSON, in December last, with an aneurism in the right popliteal space. He was discharged about the middle of April as "cured," and presented himself a month later, according to instructions, in order that it might be seen whether the cure was permanent and complete. On examination there was found in the popliteal space a trace of the old tumour, but it was very small and without the least sign of even the feeblest pulsation. Pulsation, however, was to be felt in the posterior tibial artery at the ankle, although not so distinctly as on the unaffected side. The case might, therefore, be considered one of perfect cure.

*Remarks.*—With regard to the tumour itself there was nothing especial to note; it was a typical aneurism in every respect. The patient was a healthy, well developed man of temperate habits, with no history

of syphilis and no explanation to offer for the appearance of the tumour, except the frequent and often forcible movements to which his leg would be subjected in following his employment as a carpenter. The aneurism was noticed about four weeks before admission, and was somewhat rapidly increasing in size.

To the treatment, however, of the case special attention should be drawn. Before any active measures for the cure of this aneurism were employed, the patient was subjected to the following preliminary treatment, which had previously been carried out in three cases with uniform success. 1st. He was kept in bed in a state of absolute rest. 2d. His diet was limited as far as possible to solid food, a minimum of liquids only being allowed. The patient, having these instructions before him, and possessed with an intelligent desire to carry them out, managed to subsist on ten ounces of fluid per diem, or one pint in forty-eight hours. 3d. Iodide of potassium was administered.

The perfect rest was of importance in so far as it acted by decreasing the arterial tension of the part and by preventing the aneurismal sac from being exposed to varying degrees of pressure. A diet composed as far as possible of solid foods, with but little liquid nourishment, aided considerably in increasing the fibrine of the blood, and so most favourably prepared the patient for the final and actual cure of the aneurism. The iodide of potassium was administered on account of the power it is presumed to possess of aiding the same process—viz., the increase of the blood fibrine. This action is, however, at present theoretical. This preparatory treatment was pursued for fourteen days. The only visible effect noticed was that the tumour, instead of continuing rapidly to increase, ceased at least to grow, and in fact diminished half an inch in circumference.

At the end of fourteen days the patient was anæsthetized, and Esmarch's elastic bandage and rubber band were applied to the limb. The bandage being removed, the band was kept on for one hour, the patient being under chloroform during that time. The limb was carefully watched during the process, and care was taken to prevent undue loss of temperature. Before the band was removed a number of dressers were ready at once to commence digital compression of the femoral artery in Scarpa's triangle. On the band being removed it was evident that the tumour still pulsated, but much less energetically than before. When digital compression had been applied for four hours all pulsation had entirely ceased in the tumour, but, as a matter of security, the pressure was continued for four hours longer. In a fortnight's time the patient left his bed, no trace of pulsation having been noticed since the day of the compression.

Of the two other cases referred to as having been subjected to this treatment, it may be remarked that in one the pulsation was found to have entirely ceased on the removal of Esmarch's band, while the other case was almost an exact counterpart of the present one. In both cases the cure was sound and permanent.

There are few, very few, cases of aneurism that cannot be cured by digital compression, if properly and intelligently applied, and presuming that compression be anatomically possible; and it is highly probable that that mode of treatment is much assisted by the preliminary procedure above indicated. Digital compression certainly requires a staff of good assistants, and is irksome to the patient; but it is nothing more than irksome; it is a simple and safe mode of cure, and should always have a most thorough trial before any more serious procedure is entertained. —*Lancet*, July 5, 1879.

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*Intra-Uterine Fibroid Tumours of Uterus, Sessile and Pedicellated, as Causes of Uterine Hemorrhage; Treatment for their Removal.*—Fanny R——, aged forty-eight, married, was admitted into Middlesex Hospital, under the care of Dr. HALL DAVIS, April 30th, 1879, for uterine hemorrhage. It was found to be dependent on an intra-uterine tumour, elevating the fundus nearly to the navel. She had had four labours at full term, the last ten years ago. She had not had any miscarriage. The hemorrhages had been of

three years' duration, but most profuse at her menstrual periods.

On admission, the patient had undergone the ordinary styptic treatment for hemorrhage without permanent benefit. She was very exhausted and extremely anæmic; her lower extremities were œdematous, but there was no albumen in the urine, sp. gr. 1014. As she was not then losing blood, it was thought advisable, in view of operative treatment under more favourable circumstances, to rally the patient's strength by tonic treatment.

*May* 13. That object having been fulfilled, and no hemorrhage of consequence having recurred in the interim, the connections of the intra-uterine tumour were examined to-day. The depth of the uterine cavity, measured by the sound passed to the fundus, was found to be four inches and a half. Part of the tumour occupied the cervical canal, and was adherent to the cervix for three-fourths of its circumference.

The patient was now placed under anæsthesia, commencing with chloroform, afterwards carrying it on with ether. Dr. Davis then detached with the finger the adhesions to the interior of the neck of the uterus upwards, till the rest of the growth, as high as could be reached, appeared free. He then passed up the loop of a wire-rope écraseur over the tumour till he supposed its advance was stopped by an adhesion. His next intention was at once to amputate the growth, but, the process being tedious, he decided, after he had partly crushed through it, to endeavour to remove the tumour by a combination of torsion and extractive efforts. In this way the remaining not very firm adhesions were broken across, and the tumour, by the écraseur purchase, was brought gradually through the os uteri and vagina. It exhibited on its outer surface a cast of the concave interior surface of the uterine cavity. It had been adherent to the fundus and upper part of the body of the uterus by loose tissue without a pedicle. As a safeguard against hemorrhage, the uterus was swabbed out with a sponge saturated in a solution of perchloride of iron, 1 in 4. A suppository of one-third of a grain of morphia was administered in the course of the evening.

No severe symptoms followed the operation, there has been no return of hemorrhage, and the patient is now (June 3d) rapidly gaining strength. She has already lost much of her pallor, and is able to sit up for a short time daily. She is taking tonic medicines and plenty of good nourishment. The weight of the tumour was five ounces, its length four and a half inches, its greatest circumference six and a half inches. Its structure was that of fibroid tissue, closely resembling that of the plain nucleated muscular fibre of the uterus, but not containing any of the cells characteristic of carcinomatous growth.

Dr. Davis referred, in the course of his clinical remarks, to another case of an intra-uterine fibroid tumour, of similar structure to the above, which he had removed in November, 1859, also by torsion combined with extractive efforts, preceded by preparatory separation of the more accessible adhesions. The lady the subject of it was a widow fifty-one years of age. In her case the tumour, which on removal weighed upwards of five pounds, had interfered mechanically with the function of the bladder, and had been the cause of repeated, profuse, and exhausting floodings. The growth was in the above manner gradually drawn out of the uterus, being detached at the same time from the uppermost adhesions to the fundus of the uterus, to which it was not pedicellated. The left hand grasping the upper half of the tumour, and the vulsellum forceps carefully guided and applied to its lower half, were the means of purchase employed in removing the tumour. The patient made a rapid recovery, and returned to her country home within three weeks after the operation. She has now, after nearly twenty years of a prolonged and active life, had no return of uterine disease.—*Lancet*, July 5, 1879.

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*Hæmatocele of Neck.*—J. C——, aged forty-five, a compositor, was admitted July 9th, 1878, into Charing-Cross Hospital, under the care of Mr. BARWELL, with the following history: He had always

been a fairly healthy man, and had been married for twenty-four years. Was the father of six children, five of whom were alive. About fifteen years ago he first noticed a swelling on the right side below the angle of the jaw; this was about the size of a pullet's egg, freely movable beneath the skin. About the middle of April, 1878, he had an attack of typhoid fever, which left him in a weak state. During convalescence the tumour increased very rapidly in size and became extremely tender to the touch and the seat of "burning pain." The only explanation he could offer of the origin of the tumour was that it arose from a blow he received whilst boxing.

On admission a large irregular swelling occupied the right side of the neck, about the size of the full-term fœtal head. It extended from the lobule of the right ear downwards to the sternal end of the clavicle, and lay in the course of, and underneath, the sterno-mastoid muscle, which was freely movable over it, but atrophied and expanded by pressure; it went as far back as the middle line of the posterior triangle, and along its inner border communicated pulsation could be readily distinguished. It was smooth, tense, and very hard. It was the seat of constant pain, and was very tender to touch.

On the 16th of July, by careful palpation, Mr. Barwell detected a spot near the middle of the posterior border in which he believed an indistinct fluctuation could be felt; he therefore introduced an exploring trocar and canula with some difficulty, owing to the density of the tissues. When this had passed to the depth of an inch and the trocar withdrawn, three ounces of a dark-brownish sanguinolent fluid, having the odour of sulphuretted hydrogen, was discharged.

On July 19th, at noon, the patient had a well-marked rigour; temperature 104°. There was no inflammatory signs in or about the tumour to account for this.

On July 25th, an oblique incision was made along the posterior border of sterno-mastoid muscle, and a dissection carefully made down to the tumour so as to avoid some rather large veins. The cyst was then opened by a small incision, into which the forefinger could just be introduced, and there flowed out by the side of the finger some dark grumous blood, having less fetor than that which escaped by trocar. Some clots were next broken down, and some dark decomposed blood was allowed to pass by the side of the finger. As no arterial hemorrhage followed, a long narrow-bladed bistoury was passed along the finger, and the opening enlarged to the extent of about an inch. Thirteen ounces of dark blood, fluid and clotted, came away, which, with the three ounces previously withdrawn, made up the whole quantity to sixteen ounces, but a quantity of coagulated blood was left, being strongly adherent to the walls of cavity, and very dense. The operation was conducted with all antiseptic precautions. The tumour was cystic in origin, its walls very thick and dense, and the interior rough and fasciculated. Its contents were nothing but disintegrated blood. The microscope showed a great quantity of granular matter, a number of round bodies about the size of blood-disks, and with the outlines of cells, as well as a considerable amount of finely fibrillated material.

*Remarks.*—Hæmatocele of the neck is not a common affection, and rarely attains the size of the blood-tumour in this case. One of the man's amusements—namely, sparring—might probably account for the disease, for when a young man he had himself observed that when a professional boxer allowed himself to be hit about the head he always turned his head and chest so as to receive the blow upon the side of the neck—in fact, upon the sterno-mastoid muscle, rendered tense. A sharp blow, or a succession of blows, received on this place might easily, by the rupture of a vein, have given rise to the tumour. But the chief interest lay, not in its causation, nor in its rarity, but in the great difficulty of diagnosis. The tumour lay in the course of great bloodvessels; it pulsated, and, as the sequel showed, contained blood, and yet was not an aneurism. The diagnosis before the use of exploration was most difficult, as the swelling might, but for certain small differences, have been a partially consolidated aneurism of

the carotid, into which the introduction even of a very fine trocar would have been most dangerous. These differences were: the character of the pulsation; its almost entire limitation to the line of the carotid artery; the fact that the temporal and other arteries beat nearly as strongly as on the opposite side; the great tenseness and hardness of the tumour, and the power of shifting it, though very slightly, outwards, without moving simultaneously the vessels of the neck. Yet these differential signs, plainly diagnostic when thus catalogued, could, owing to the size of the tumour and the great condensation of the surrounding tissues, be made out only by most careful examination. Neither did the character of the blood evacuated by puncture entirely clear away the possibility of the tumour being aneurismal; hence the opening was made in a manner which might, if necessary, allow it to be converted into the old operation for aneurism.—*Lancet*, June 21, 1879.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*On Disinfection for limiting the Spread of Yellow Fever.*—The National Board of Health publishes (*National Board of Health Bulletin*, Aug. 2, 1879) the following memoranda on disinfection:—

1. It is prudent to assume that the essential cause of yellow fever is what may for conciseness be called a "germ," that is, something which is capable of growth and propagation outside the living human body; that this germ flourishes especially in decaying organic matter or filth, and that disinfection must have reference both to the germ, and to that in or on which it flourishes.

2. Disinfection, when used in a place not infected, for the purpose of rendering filth, or foul soils, waters, etc., incapable of propagating disease germs, is a poor substitute for cleanliness, and is mainly useful to make the process of cleansing odourless and harmless. The best disinfectants for this purpose are sulphate of iron, carbolic acid, fresh quick-lime, fresh charcoal powder, chloride of zinc, chloride of aluminium, and permanganate of potash.

3. The two great difficulties in destroying the vitality of the germ of yellow fever are, first, to bring the disinfecting agent into actual contact with the germ; and, second, to avoid injuring or destroying other things which should be preserved.

4. *When the germ of yellow fever is dry or partially dried no gaseous disinfectant can be relied on to destroy it.* It must either be moistened or subjected to a dry heat of not less than 250° F. to obtain security.

5. In disinfecting or destroying infected clothing, bedding, or movable articles, *move them as little as possible while dry.* Before disturbing them have them thoroughly moistened either with a chemical disinfecting solution or with boiling water, in order to prevent the diffusion of dried germs in the air in the form of dust.

6. The best method of disinfecting rooms, buildings, ships, etc., is still doubtful, owing to the difficulty of destroying the vitality of dried germs.

The Board proposes to have this subject carefully investigated, and in the mean time advises thorough scrubbing and moist cleansing to be followed by the fumes of burning sulphur at the rate of 18 ounces per 1000 cubic feet of space to be disinfected.

The sulphur should be broken in small pieces, burned over vessels containing water or sand, which vessels should be distributed in the closed space to be disinfected at the rate of one to each of 100 square feet of area of floor.

7. No patented compound known to to the Board is superior as a disinfectant to the agents above mentioned, and none so cheap. Some of these patent disinfectants are good deodorants, but *the removal of an unpleasant odour is no proof that true disinfection has been accomplished.*

8. In districts where yellow fever prevailed last year the following precautionary measures should be taken:—

(*a*) Textile fabrics of every description which were exposed to yellow fever infection during the year 1878 and which have remained packed or boxed in a closed place since such exposure, should not be opened or unrolled, but should either be

burned or placed in boiling water for half an hour or more, or in suitable heated ovens, or disinfected according to the nature and value of the individual article or articles.

(*b*) Every house or room in which cases of yellow fever occurred in the year 1878, and since that time have remained unoccupied, should not be opened for occupation until they have been thoroughly cleansed and disinfected by persons acclimated to yellow fever.

(*c*) Every privy, vault, underground water-cistern, dry well, or closed cellar connected with a house in which yellow fever existed last year, and which may not have been opened since that date, should not be reopened, but if possible should be covered with several feet of earth.

(*d*) Every suspicious case of sickness should be at once isolated, and every possible precaution taken to prevent infection by providing attendants who have had the disease, and thorough disinfection of all discharges from the sick. If the disease prove to be yellow fever all articles of clothing and bedding used about the sick should be burned, the house should be vacated, and every room tightly closed and fumigated with burning sulphur.

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*Medical Officers as Inspectors of Foreign Ports.*—In response to the request of the National Board of Health, the Secretary of the Navy has detailed Dr. Daniel M. Burgess for the inspection of vessels and issuing certificates at Havana, and Medical Inspector Somerset Robinson for like duty at Matanzas.

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*Colour-Blindness among Railroad Employés.*—It is stated in the *Nation* (Aug. 21, 1879) that Dr. B. Joy Jeffries has made an official examination of ninety-four engineers, firemen, and switchmen of the Boston and Lowell Railroad, with the result of proving two of these employés to be colour-blind (red-blind), and seventeen to be "below the visual standard," whether as regards acuteness of vision or perception of colour.

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*American Ophthalmological Society.*—The annual meeting of this Society was held at Newport on July 24th. Dr. H. D. Noyes, of New York, President, in the Chair. The following officers were elected for the ensuing year: President, H. D. Noyes, M.D., of New York; Vice-President, W. F. Norris, M.D., of New York; Secretary, Dr. R. H. Derby, of New York. The next annual meeting will be held at Newport, in July, 1880.

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*American Otological Society.*—The annual meeting of this Society was held at Newport, R. I., July 23, Dr. Albert H. Buck, of New York, presiding. The following officers were elected for the ensuing year: President, Albert H. Buck, M.D., of New York; Vice-President, Charles H. Burnett, M.D., of Philadelphia; Secretary, Dr. J. J. B. Vermyne, of New Bedford, Mass. The next meeting will be held at Newport, in July, 1880.

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*Iowa State Medical Society* held its twenty-seventh annual meeting at Davenport, June 3d, 4th, and 5th. Dr. A. M. Carpenter, of Keokuk, President, in the Chair. The following office-bearers were elected for the ensuing year: President, Dr. George P. Hanawalt, of Des Moines; Vice-Presidents, Drs. A. W. McClure, of Mt. Pleasant, and D. Schofield, of Washington; Secretary, Dr. J. F. Kennedy, of Des Moines. The next meeting will be held at Des Moines, on the second Tuesday of January, 1880.

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*Medical Society of North Carolina* held its twenty-sixth annual meeting at Greensborough, May 20th, Dr. Charles Duffy, Jr., of Newbern, presiding. The following officers were elected for the ensuing year: President, Dr. J. F. Shaffner, of Salem; Vice-Presidents, Drs. J. K. Hall, of Greensborough, W. C. McDuffie, of Fayetteville, W. R. Wilson, of Granville, and R. F. Lewis, of Luncketon; Secretary, Dr. L. J. Picot, of Littleton.

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*Medical Association of Montana.*—A Territorial Medical Society was organized, January 29, 1879, under the name of "The Medical Association of Montana," and the following officers were elected for the ensuing year: President, Dr. E. T.

Yaqu, of Virginia City; First Vice-President, Dr. Wm. Parberry, of White Sulphur Springs; Second Vice-President, Dr. G. W. Monroe, of Bozeman; Recording Secretary, Dr. W. R. Bullard, of Helena.

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*Medical Department of Yale College.*—The medical department of Yale College announces a graded course of instruction extending over three years. Preliminary examinations are required for admission, except from those who present a degree in Letters or Science, or have passed an examination for admission to Yale College or some similar institution, and are conducted in writing. Examinations chiefly in writing, will be held at the end of each year to determine the standing of students with reference to their advancement to the studies of the succeeding year.—*Med. Record*, August 23, 1879.

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*The Gross Testimonial.*—The committee having in charge the arrangements for the complimentary dinner tendered to Prof. S. D. Gross by his medical friends in April last, have just published in neat pamphlet form a report of the proceedings on the occasion. The volume, which contains all the addresses, is prefaced by an excellent photograph of Prof. Gross, and is published by Lindsay & Blakiston.

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## FOREIGN INTELLIGENCE.

*New Method of Preventing Cystitis after Cantharides.*—M. Guyot recommends (*Le Progrès Médical*, May 31, 1879), the incorporation of a certain quantity of carbonate or bicarbonate of soda in place of powdering blisters with camphor, as is generally done. For this purpose he mixes equal parts of carbonate of soda and cantharides powder, and then spreads the mixture upon the plaster. The blister is fixed by strong pressure with the palm of the hand, and is covered with a layer of oiled silk. The vesicant acts as rapidly and as surely as one made with the simple powder of cantharides without any admixture with other substances. The experience of the many years during which it has been in use at the Bordeaux hospitals tends to show that the addition of the soda salt is a much safer preservative than camphor against those accidents to the neck of the bladder which occur so frequently after the application of blisters, whether or not they have been previously camphorated.—*Practitioner*, August, 1879.

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*Treatment of Scrofula and Tuberculosis.*—Dr. Jules Regnard has prescribed the chlorhydro-phosphate of lime in a case of tuberculosis after scrofula in a child with the greatest success. The preparation was given to the extent of a tablespoonful at each meal without any other treatment except careful dietary, fresh air, sunlight, and exercise. Commenting upon this case, Dr. Reguard wishes it to be distinctly understood that he has no intention of throwing into disrepute other modes of treatment. That phthisis is not a simple disease is well known. There appears to be one dominant condition more especially marked at the commencement of the disease—a general poverty of the system, which, at first a result of the disease, at a later period favours its further development. It is in this state that the beneficial effect of the chlorhydro-phosphate of lime are most chiefly noticeable. This remedy restores and stimulates the appetite, which has been long lost, to a greater extent than any other. It facilitates digestion and assimilation, and it acts directly upon the general as well as upon the local conditions. Side by side with this dominant affection, however, various symptoms call for special treatment. Thus in the majority of cases creosote is used for the purpose of moderating expectoration, and because it appears to possess a kind of topical action. Sulphate of atropia gives good results in sweating. In certain cases, too, arsenic is beneficial, and every one has experienced the remedial effects of hygienic treatment, and a change of scene chosen judiciously for each case. Cod-liver oil, which is so generally employed, may also afford great benefit whether it be used alternately with the chlorhydro-phosphate of lime, or simultaneously with that remedy, by rendering its digestion more ready. No means should therefore be

left untried, but, although varying symptoms should be treated with a variety of remedies, the chlorhydro-phosphate of lime should be employed in every case of simple phthisis. — *Practitioner*, August, 1879.

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*Anæsthesia produced by the Inhalation of Iodoform.*—A gentleman, aged twenty-five, was attended for suspected ulceration of the urethra, and a gram of finely-powdered iodoform was prescribed that he might make a local application. On the following day, towards evening, as he had not been seen since the previous night, his friends determined to enter his room. They did so, and then found him extended upon his bed in a deep sleep. As he did not answer to repeated shouts he was well shaken, and was at length aroused. The patient was unable to account for his abnormal sleep, and it was known that he had not committed any excess on the previous day. Two hours after awakening, and after a copious repast, his clothes and breath still smelt strongly of iodoform, the box containing which had been found on his bed with the powder scattered about. No ill effects, with the exception of a slight giddiness, were experienced. The case is interesting from the fact that so small a quantity as a single gram of iodoform, and that only in small part absorbed by the mucous membrane of the respiratory tract, shall have provoked so complete anæsthesia for twenty-four hours. During the whole of this time, too, the air in the room was being constantly renewed, since one of the windows was partially open. Experiments made upon a variety of animals in regard to the inhalation of iodoform have hitherto shown that it only produces a transient anæsthesia, with symptoms which recall those produced by protoxide of nitrogen, and in no case a deep and persistent sleep. (*Le Practicien*, March 17, 1879.)

Two somewhat similar cases are reported in the *Lancet* for May 31st. The maximum dose was .8 gram daily in a pill, and the symptoms resulting were those of poisoning, and not of mere anæsthesia. The cases were two in number, and were published by Oberlander. The symptoms of poisoning occurred in one case (a woman of twenty-six years of age) after forty-two grams of iodoform had been taken in eighty days; in the other case (a woman sixty-nine years of age) after five grams had been taken in the course of seven days. The symptoms produced were giddiness, vomiting, and deep sleep, from which the patient could be roused with difficulty. This somnolence was interrupted by periods of excitement, each lasting several hours, and was followed by delirium, intense headache, sense of impending death, spasmodic contractions of the facial muscles, and in the case of the younger patient, diplopia. The functions of the other sensory organs were not disturbed, and the pupils presented a normal reaction. Deep inspirations alternated with apnœa of about half a minute's duration. After five or six days the toxic symptoms gradually lessened and passed away.—*Practitioner*, August, 1879.

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*Sodium Benzoate in Infectious Diseases.*—Prof. Klebs, of Prague, announces (*Der Practische Arzt.*, Jan. 1879), that the benzoate of soda is the best antiseptic in all infectious diseases. It may be taken in large doses with impunity, and acts so far as the author's experiments upon animals show, as a more powerful disinfecting agent than quinine or salicylate of soda. The experiments were conducted upon animals inoculated with diphtheria and tubercle, and the benzoate of soda was injected hypodermically. Prof. Klebs, reasoning from the results obtained with rabbits, argues that in a man weighing fifty kilograms a daily dose of 30–50 grams of benzoate of soda would render the poison of diphtheria inoperative. Such large quantities, however, do not appear to be absolutely necessary, as the infection can be successfully combated in men by the administration of much smaller amounts. Thus 25 grams per diem may be given with good results, though the more ordinary dose is 10–15 grams in the same time. The mean of these amounts is probably the best. The drug may be mixed with twice its weight of Elæo. sacch. menthæ, 6–15 grams of

the powder being given for a dose dissolved in half a wineglassful of water. Sodium benzoate is prepared by dissolving crystallized benzoic acid in water, neutralizing at a slight heat with a solution of caustic soda, drying and then allowing the solution to crystallize over sulphuric acid under a bell-glass.—*Practitioner*, August, 1879.

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*Sodium Salicylate in Chronic Rheumatism.*—Mr. Ernest H. Jacob, late Resident Physician to the Leeds Infirmary, in a communication to the *British Medical Journal*, Aug. 2, 1879, says there are few better established facts in the history of therapeutics than the success in acute rheumatism of treatment by the salicylates. Very little evidence, however, has been given of its effect in the chronic forms. A few observers, after a short trial, declared it useless; and few voices have been heard in its defence.

In a paper read before the British Medical Association in 1877, I gave short notes of about thirty cases so treated. I have now accounts of 57 more, all well marked cases of chronic articular rheumatism treated during the two past years as out-patients at the Leeds Infirmary. Making the usual allowance for the imperfection of out-patient notes, I find that, out of the whole number of cases in which the drug was given, viz., 103, 16 did not return after the first visit. Next, out of the 87 of whom notes had been taken, 61 (70 per cent.) derived some benefit from the drug, which was in most cases sodium-salicylate in doses of fifteen to thirty grains three times a day. The remaining 26 felt no improvement, and in four cases some sickness was noted. In comparatively few of the cases was the relief given as speedy as that afforded in the acute disease; but, considering the generally unsatisfactory nature of the treatment of chronic rheumatism by drugs, I think we may say that sodium salicylate deserves a further trial.

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*A New Preparation of Quinia soluble in Water.*—In the *Centralblatt f. d. Med. Wiss.*, June 14, Dr. Jaffe, of the Hamburg General Hospital, reports the results of the trials which he has made of a new preparation of quinine termed *quinia bimuriatica carbamidata*, formed by Drygin, from a combination of twenty parts of muriate of quinia, twelve of muriatic acid, and three parts of urea. The resulting salt is soluble in equal parts of water, and is therefore eminently suitable for the administration of large doses of quinine by the hypodermic method. The trials that have been made of it at Hamburg have proved so successful that it is highly desirable it should be more widely known. A 50 per cent. solution has always been employed, so that a Pravaz syringe full (holding one gramme) will contain a third of a gramme of the salt. The quantity injected varied from a half to three syringes full. The local irritation consequent on the injection was in most cases very slight, and at most consisted in a circumscribed burning pain (which was soon relieved by cold Goulard water), without redness or swelling. Doses of a gramme produced in men scarcely any subjective sensations, and the noises in the ear complained of by women and children soon disappeared. The anti-febrile effects were evident and certain, intermittents disappearing after the second or third injection. This form of administration seems especially indicated (1) in those sensitive persons who have an invincible objection to taking quinine by the mouth; (2) when gastric affections coexist; (3) in children; and (4) in hospital and pauper practice, as a much smaller quantity of quinine is required than when it is administered internally. —*Med. Times and Gazette*, July 12, 1879.

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*Death from Chloroform.*—The *British Medical Journal* for July 19 contains a report of a case of this. An inquest was recently held at Mildenhall, in Suffolk, on the body of a girl aged 14 years, who had died at the St. Leonard's Cottage Hospital at that place, during an operation whilst under the influence of chloroform. The medical evidence showed that the girl was admitted for inflammation of the elbow-joint. Abscesses formed in the arm which required opening, and she had been twice chloroformed during the performance of operations. On the third occasion, when fresh abscesses had shown themselves, the

chloroform was taken very easily and calmly, but the breathing soon became noisy and embarrassed, and the lips and face began to turn livid. The usual restoratives were applied without avail, and death ensued.

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*Intra-uterine Therapeutics.*—Dr. Cnopf of Nuremberg (*Memorabilien*, part 5, 1879) has lately tried the experiment of treating rachitis during intra-uterine life. The patient was a woman who had given birth to several rickety children. Both parents were seemingly healthy, but showed traces of rickets. Dr. Cnopf treated the woman with phosphates for several months previously to her delivery. A very well formed healthy male child was born, which did not present the slightest symptoms of rickets.—*British Med. Journal*, July 19, 1879.

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*Uterine Temperatures.*—Dr. Runge, in making experiments on rabbits, found that as soon as the temperature of the maternal organism rose to 105 8° Fahr., the fœtus perished, though it was alive at a temperature of 104.9° or 105.2°. Professor Zweifel observed a similar fact in a human fœtus. As long as the maternal temperature was 105.8°, the fœtus was alive; but when it rose to 108.6°, the child died.—*British Med. Journal*, June 14, 1879.

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*The Cystoscope.*—The following description of this instrument, which has been invented by Dr. Nitze, and constructed by M. Leiter, is taken from the *Allgemeine Wiener Medicinische Zeitung*, May 13th. The cystoscope, or instrument for illuminating the urethra and bladder, consists of a long tube or catheter, which ends in a point, and into which another tube with very thin walls, containing the optical apparatus, is inserted. A platinum wire, which is heated to white heat, runs through the outer tube, in the tapering end of which a small opening is cut and provided with a well-fitting glass. Two different instruments are required here, one only for the purpose of examining the urethra in all its parts, and the other for examining such portions of the wall of the bladder as would stand perpendicularly to the longitudinal axis of the instrument, whatever may be its position. Therefore, in the first cystoscope, the opening is situated on the convex part of the angle, which is formed by the point and the remainder of the tube, and necessarily on the anterior part of the former; and in the second cystoscope on the concave part of the same angle and on the posterior part of the point. Into the opening of the cystoscope No. 2 is fitted a rectangular prism. Its hypothenuse acts as a mirror in reflecting the rays of light which fall on it. This latter instrument is so contrived that it can be rotated around its longitudinal axis without interrupting either the electrical current or the water-supply. The wire is heated and maintained at the same temperature by means of a very powerful constant Bunsen's battery, which has been somewhat modified by M. Leiter. By a special contrivance, the air within the vessels which contain the acids may be either compressed or rarefied, so that the battery, which consists of two elements, can be filled or emptied in the space of five minutes. It can easily be moved, and may also be used for galvano-caustic operations. In order to prevent the heated wire from coming into contact with the mucous membrane, the tube itself is kept cool by means of a continuous stream of water which circulates within its walls through two separate channels, which run into each other at the point of the catheter. The space between these two channels is occupied by an isolated wire. The two poles are represented by the catheter and the above-named wire. A loop made of platinum wire and connected both with the tube and the isolated wire is placed at the confluence of the channels. In this way, the wire may be heated to white heat, while the tube remains perfectly cool. The water is supplied from a vessel which is suspended from a considerable height, and connected with an India-rubber tube. Two filters are placed within the latter, at a certain distance one from the other, for the purpose of keeping back any foreign bodies which might happen to be in the water and obstruct the instruments. A special automatic interrupter is provided for the purpose of breaking

the contact the moment the water-supply should cease to flow. In short, the whole apparatus is most ingeniously contrived, and will doubtlessly prove a most efficient help to internal examinations. The instruments for examining the stomach, œsophagus, etc., are not yet completed.—*British Med. Journal*, May 31, 1879.

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*The Audiometer*.—At the last meeting of the Royal Society, Dr. Richardson demonstrated the action of a new instrument which he has named the audimeter, or audiometer, and which has just been invented by Professor Hughes, the discoverer of the microphone. The audiometer is used as a precise measurer of the sense of hearing. It is formed of a small battery of one or two Leclanché cells, a new microphonic key, two fixed primary coils, a granulated insulated bar, to which at each end one of the fixed coils is attached, a secondary induction coil, which moves along the graduated bar, and a telephone, the terminals of which are connected with the terminals of the induction coil.

The principle of the audiometer is based on the physical fact that when the battery is in action, and a current is passing through the two primary coils, the secondary coil on the bar becomes charged, by induction, whenever it is brought near to either of the primary coils; but when it is brought to the precise centre between the primary coils there is a neutral point, or electrical balance, where the electric phenomena from induction ceases to be manifested. By placing a microphonic key between the battery and one of the primary coils, and by attaching the terminals of the induction coil to the telephone, Professor Hughes was able to make the telephone produce sounds whenever he brought the induction coil near to one of the primary coils and moved the microphonic key so as to make it play on a fine needle suspended in the circuit. When the induction coil is close to one of the primary coils, the noise is very loud, but as the coil is moved towards the centre of the bar the noise diminishes, until it ceases at the centre altogether. The scale on the bar is graduated into two hundred degrees, representing units of sounds from 200 to 0, or zero. At 200 all who can hear at all can hear the vibration of the drum in the telephone. At 0 no one can hear, while between the two points there are two hundred gradations of sound, from the highest down to zero.

In using the instrument, the telephone is put to the ear of the listener while the operator moves the microphonic key, and at the same time shifts the induction coil on the graduated bar so as to measure the hearing power of the person under examination. Dr. Richardson presented a preliminary report to the Royal Society on his first experiments with the audiometer, and showed that already, by its means, some useful and practical as well as curious facts had been obtained. Amongst many of these was one relating to an inquiry as to the best material for making artificial tympanums and the best form of artificial tympanums for cases of defective hearing from perforation or destruction of the natural drum. He had found gold made into the form of little cups or capsules exceedingly effective for this purpose. The audiometer promises to become one of those useful adjuncts to practice of which we shall say ultimately, How did we get on before it was known?—*Lancet*, May 31, 1879.

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*British Medical Association*.—The forty-seventh annual meeting of this Association was held at Cork, on the 5th, 6th, 7th, and 8th of August, under the Presidency of Dr. O'Connor, of Cork. The following Americans were noted as among the distinguished foreigners who were present: Drs. Da Costa and Turnbull, of Philadelphia; Sayre, Loring, Agnew, Seguin, and John P. Gray, of New York; Yandell, of Louisville; Byford, of Chicago; Hogden, of St. Louis, and A. B. Palmer, of the University of Michigan. The meeting in 1880 will be held at Cambridge, and Professor Humphrey will be the President-elect.

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Obituary Record.—On July 4, aged 47, Charles Frederich Maunder, Surgeon to the London Hospital.

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We can heartily commend this volume to the medical student as a good guide to the study of laryngoscopy and rhinoscopy penned by the hand of a gentleman fully familiar with the subject of which he writes.—*N. Y. Med. Record*, July 19, 1879.

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**HENRY C. LEA—Philadelphia.**